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www.ccsa.ca • www.ccdus.ca November 2023 Policy Brief

Comparing Drug Treatment Court Principles to Evidence-Based Practice

Issue

Improving the design, implementation and evaluation of the current drug treatment court (DTC) model used in Canada is needed for them to achieve their intended outcomes for participants. A DTC is a diversion model that keeps substance use–related issues within the criminal justice system while providing alternatives to incarceration. Overall, many approaches used by DTCs to manage substance use disorders (SUDs) do not align with current evidence and healthcare-based best practices. DTCs in Canada currently are not meeting 44 per cent of international standards and are only partially meeting 23 per cent of these standards. For DTCs to improve their effectiveness, their programs must be ethical and evidence-based, and address social determinants of health. There is also a fundamental concern that DTCs address substance use within a justice context, rather than aligning with current evidence that it should be addressed as a public health, health and social issue.

DTC participation is often referred to as "voluntary," as participants are given a choice to participate in the program or continue through the court system on the original charges. If they choose the DTC program, they are required to abide by all conditions imposed by the court. However, participants must first plead guilty to all relevant criminal charges to gain admission to a DTC program. Some argue that this constitutes "legally coerced" treatment, as the alternative to DTC participation is incarceration or another formal criminal justice sanction, such as probation.[1,2] Additional coercive aspects of DTCs are the requirements for abstinence and justice system sanctions for lack of progress and compliance within the program. The use of sanctions such as jail for non-compliance is at odds with the humanistic and supportive intent of international drug use treatment standards.[3] This presents the possibility of people being viewed criminally because of their SUD, an acknowledged health condition, rather than seeing the criminal behaviour as a byproduct of a SUD. The use of punishment in this context is stigmatizing and may impede or prevent participants' access to health and wellness services.[4] Moreover, DTCs do not constitute a complete alternative to conviction or punishment, as program participants may only receive a reduced sentence or a term of probation rather than a full dismissal of charges.[5] As a result, the criminal conviction can remain and create obstacles to achieving social stability, such as stable housing and employment.

To develop and expand effective, evidence-based and ethical treatment for drug use disorders,* the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC) co-

* Alcohol is not included in the definition of drugs offered by the WHO and UNODC.

developed a comprehensive set of seven key principles that include 62 standards (see Appendix A).[3] Importantly, the standards make specific reference to the treatment of problematic substance use for people who are involved in the criminal justice system, including treatment provided as an alternative to conviction and punishment. The standards also support the evaluation and ongoing improvement of services as well as the development of new policies and treatment systems.

This brief explores the extent to which the Canadian DTC model adheres to international standards of care and offers ways to improve adherence to these standards to enhance the effectiveness of DTCs. While Canada has its own DTC principles, this brief has opted to review the adherence to the WHO and UNODC international standards due to their greater public transparency and overall effectiveness at holding DTCs to quality standards. The intent of this review is not to discredit existing DTC programs but to shed light on opportunities for increased success. It provides guidance to DTC service providers and policy and decision makers at the federal, provincial and municipal levels. It outlines how they can follow evidence-based recommendations to improve adherence to the WHO and UNODC international standards of care for the design and delivery of evidence-based interventions to individuals who are challenged by substance use. It is complementary to another brief, *Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement*.[6]

Background

The following DTC principles, adopted by the Canadian Association of Drug Treatment Court Professionals (CADTCP), have been applied in Canada.[5]

1. DTCs integrate substance use disorder treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defence counsel promote public safety while protecting participants' Charter rights.
3. Eligible participants are identified early and placed in the DTC program as promptly as possible.
4. DTCs provide access to a continuum of drug, alcohol and other related treatments and rehabilitative services.
5. Compliance is objectively monitored by frequent substance testing.
6. A coordinated strategy governs DTC response to participants' compliance and non-compliance.
7. Swift, certain and consistent sanctions or rewards for non-compliance or compliance.
8. Ongoing judicial interaction with each DTC participant is essential.
9. Monitoring and evaluation processes measure the achievement of program goals and gauge effectiveness.
10. Continuing interdisciplinary education promotes effective DTC planning, implementation and operations.
11. Forging partnerships among courts, treatment and rehabilitation programs, public agencies and community-based organizations generates local support and enhances program effectiveness.
12. Ongoing case management providing the social support necessary to achieve social reintegration.
13. Appropriate flexibility in adjusting program content, including incentives and sanctions, to better achieve program results with particular groups such as women, Indigenous people and minority ethnic groups.

DTCs in Canada are encouraged to incorporate these principles into their policies and procedures. However, based on existing studies (see *Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement*)[6] and limited public information available regarding DTC programming across the country, it appears that this has not been done, at least not publicly. Of note, the above principles do not specify the target population for DTCs. The existing literature does not provide details about evidence-based treatment models and approaches recommended by medical professionals and people with lived or living experience (see *Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement*).[6] As a result, the appropriateness, quality, evidence-based approach, evaluation and operationalization of treatment are left outside of the principles. This leaves a majority of the DTC practice without principles or standards guiding its operations.

The WHO and the UNODC comprehensive series of principles and standards describe treatment methods to match the needs of people at different stages and severities of SUDs in a manner consistent with the treatment of any chronic disease or health condition. The standards define requirements for any treatment method to be considered safe and effective, regardless of the treatment philosophy used or the setting in which it is applied.

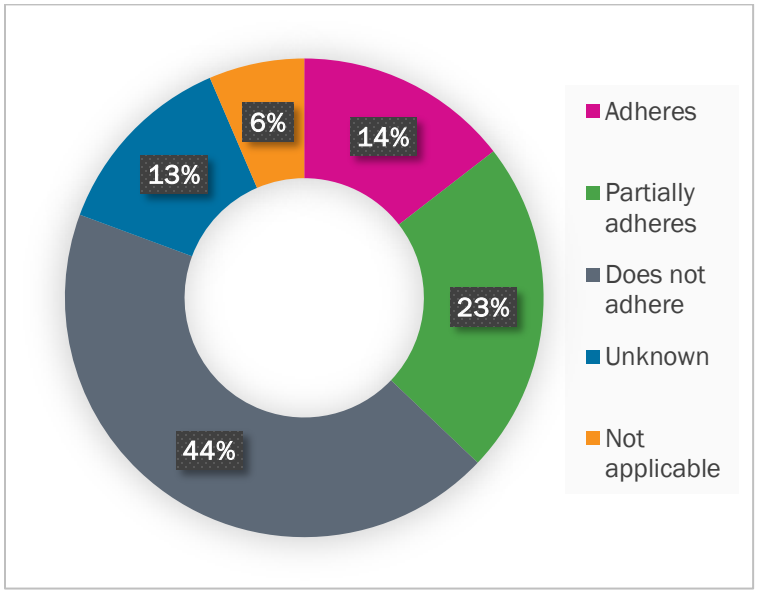
These standards underscore that treatment and support services for problematic substance use are best managed by the public health system.[3] They state that all individuals, regardless of their situation, have the right to proper, evidence-based support. The goal of treatment is to be voluntary, compassionate and person-centred, with a focus on improving health and quality of life. For a full list of principles and standards, see Appendix A. Moving toward greater alignment with these care standards will improve treatment quality through evidence-based and ethical practice.

In contrast with the WHO and UNODC international standards that assess the **design** and **content** of an effective substance use program, the CADTCP principles are more **descriptive**. The CADTCP principles are broad and focus on describing the process of running a DTC rather than setting standards for the delivery of appropriate, evidence-based care that meets the unique needs of DTC participants. As such, to improve participant outcomes, assessing where DTCs in Canada stand in relation to these international standards of care is a strong place to start.

How are DTCs in Canada Meeting International Treatment Standards?

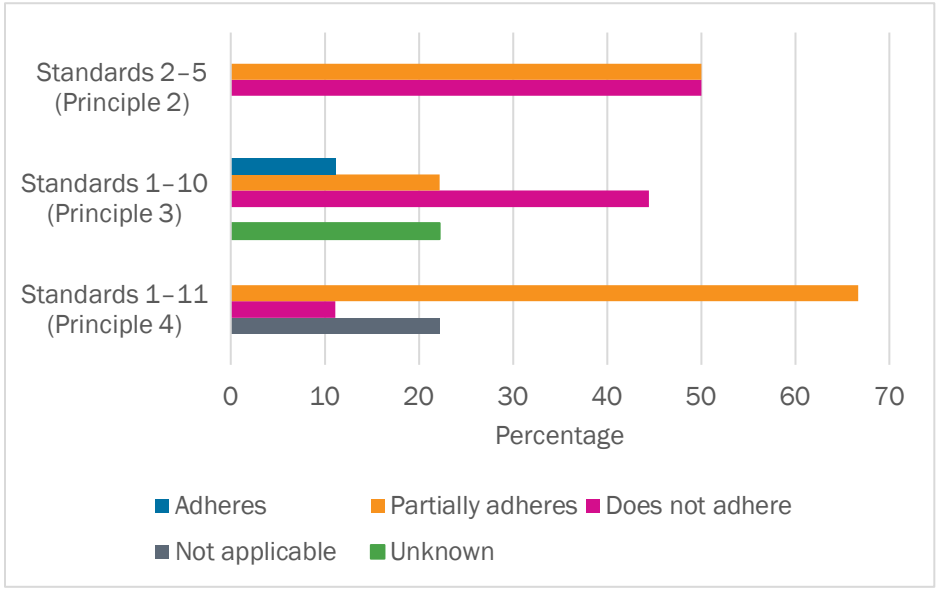
This section reviews existing DTCs in Canada in relation to relevant international standards. The full set of standards (see Appendix A) has been used to guide the discussion below. Several DTC practices are not aligned with the international standards of care for treating SUDs. Figure 1 presents the degree to which DTCs adhere to the international standards for the treatment of drug use disorders; Appendix B shows the data for this figure. Figure 2 presents the degree to which DTCs adhere to principles specifically related to justice-involved people (i.e., principles 2, 3 and 4); Appendix C shows the data for this figure. It should be noted that this brief reviewed publicly available information that may not reflect the full extent of what is applied in practice.

Figure 1. Review of Canada's DTC adherence to the international standards for the treatment of drug use disorders



Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications of DTCs.

Figure 2. Selective comparison of Canada's DTC adherence to the standards under principles 2, 3 and 4 of the international standards for the treatment of drug use disorders



Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications of DTCs. The data tables for this figure are available in Appendix C.

As these figures show, DTCs in Canada are not currently meeting 44 per cent of the international standards and are only partially meeting 23 per cent of these standards.

Many DTC providers in Canada appear to offer a one-size-fits-all treatment model that assumes that all participants require the same type, intensity and duration of treatment. This goes against the needs-based model of assessment and treatment planning outlined in the international standards of care.[3] The treatments provided within many DTC programs are not designed to respond to unique situations and needs of justice-involved people who experience substance use challenges. The extent to which DTCs respond to the needs of people with mental health disorders and other historically marginalized groups is unclear and dependent on local services. The availability of health and social support services in communities varies widely across Canada,[7] meaning individuals do not have equitable or consistent access to the continuum of services that support wellness as suggested by the international standards.

A multidisciplinary team model, as described in the international standards (see Appendix A, principle 4, standard 4.6), is not used frequently in DTCs in Canada. It is unclear whether DTC treatment providers have the necessary training, skills and experience to work effectively with justice-involved people with SUDs. It is also unclear whether court officials, such as judges and lawyers, consistently receive specialized training to ensure they understand substance use challenges. This includes the training to comprehend a medical diagnosis of SUD that is required to begin the DTC process. This is important, as the DTC Crown attorney is responsible for assessing applications against eligibility criteria (e.g., criminal behaviour that is directly or indirectly related to substance use).[7] Moreover, judges and attorneys can influence treatment decisions, including individual treatment plans.[8] For example, what an individual is charged with may influence the judge's or attorneys' position about the level or type of treatment used. Without training to understand the complexities of substance use, inappropriate referrals can occur. DTCs represent one of the only contexts in which legal professionals play a key decision-making role in what is fundamentally a public health, health and social issue. This process does not align with evidence-based treatment and can be stigmatizing to DTC participants as their health is being handled as a criminal justice matter.

There is no clear evidence DTC programs have been designed, implemented and evaluated specifically to meet the unique treatment needs of justice-involved people. It is unknown whether the programs offered to DTC participants have been compared to similar programs, such as prison-based interventions for substance use concerns. There is also a lack of evaluation studies on the effectiveness of DTCs that follow a quality study design, including a lack of randomized clinical trials (see *Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement*[6]). As a result, DTCs are currently not being fully guided by or providing participants with evidence-based treatment.

There is also a lack of documented involvement from people with lived or living experience of substance use in the design, operation and evaluation of DTC programs. This is evident in the consistent use of stigmatizing language in documents, materials and websites relating to DTCs in Canada, which violates the recommended international standards of care. For instance, instead of person-first language, stigmatizing terms are used such as substance "abuse," substance "misuse," "addicted," "clean" or "dirty" urinalysis test results, "slip," "lapse," "relapse" and "overdose." This is coupled with the widespread use of more stigmatizing terms used within the criminal justice system, such as "offenders," "criminals," "inmates," and "prisoners." Furthermore, the threat of jail or prison as sanctions limit the role and impact of participant voices in evaluation and research, as participants are hesitant to provide candid feedback about their program.[9]

Concluding Considerations

Available information on DTCs in Canada indicates that DTCs lack clear and specific standards for the delivery of care to participants. DTCs do not fully align with international standards for effective treatment, and they are not adhering to the existing standards. DTCs in Canada can improve adherence to relevant WHO and UNODC international standards of care for the design and delivery of evidence-based interventions to individuals who use substances. This is necessary because people with SUDs deserve nothing less than ethical and evidence-based standards of care similar to those applied to the treatment of other health conditions, such as diabetes or cancer. Treatment programs for justice-involved people should embody the same foundational standards of care as those offered to other members of society.

Below is a list of recommendations that focus on improving the effectiveness of DTCs. These recommendations have been shaped by the findings of a complementary brief (see *Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement*). This complementary brief explores the evidence to understand whether DTCs are effective in achieving their intended purpose while also examining the factors that contribute to the health and social well-being of people who use substances.

Recommendations

1. Adopt the principles and standards of the WHO and UNODC to develop and expand upon effective, evidence-based and ethical treatment for DTC participants.
2. Adopt the use of evidence-based standardized instruments for screening and assessment to determine clinical eligibility against established inclusion criteria, including reserving the administration of these instruments for medical and social experts with specific training in substance use care.
3. Actively ensure that treatment decisions regarding the type, intensity and duration of care are determined entirely by trained clinical staff and not court officials, such as judges and attorneys.
4. Adopt the use of collaborative treatment plans, which centre the participant's personal goals and preferences such as reduced substance use as opposed to imposed and monitored abstinence.
5. Ensure that offences related to personal possession are not criminalized and do not result in jail time.
6. Adopt restorative and transformative justice ideals of improving social determinants of health, including connecting participants to services and supports that will address SUDs and other factors contributing to involvement with the criminal justice system.
7. Dedicate resources to the collection of adequate data, obtaining feedback from participants and DTC team members, and using professional evaluators to assess adherence to the principles and standards for the delivery of effective care to participants. More data can lead to better recommendations on how DTCs can move toward full alignment with the key principles and standards for the treatment of substance use to improve treatment quality and outcomes.
8. Examine court admission and retention data to identify disparities in demographic characteristics, such as ethnicity, age and gender, and aim to have demographically representative teams and treatment partners that reflect the communities they serve.

9. Monitor court admission and retention data to see whether DTCs impact the overrepresentation of Black, Indigenous, and racialized people and other historically marginalized groups within the criminal justice tract associated with substance use and respond accordingly to the results.
10. Provide anonymous channels for participants to provide feedback on important issues like equity and inclusion, treatment planning, or any interpersonal concerns.
11. Consult people with lived or living experience of substance use in the design, operation and evaluation of DTC programs.
12. Remove stigmatizing language in documents, materials and websites relating to DTCs and provide destigmatizing language training to DTC providers.
13. Ensure DTCs constitute a complete alternative to conviction or punishment for participant graduates by guaranteeing the removal of a criminal record in relation to the offence(s) the participant was admitted to the DTC for.

Addressing these recommendations would help DTCs align with their original purpose: to offer therapeutic and health-based services as alternatives to traditional legal sanctions. It is necessary for DTCs to adopt evidence-based and ethical strategies to better assist their participants. This includes expanding beyond the evaluation measures of reoffending and cost savings and instead prioritizing DTCs' impact on substance use, health and overall wellness, including social determinants of health, such as housing and employment. However, despite these recommendations, the fundamental concern that DTCs address substance use within a justice context, rather than aligning with current evidence that it should be addressed as a public health, health and social issue, remains.

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Appendix A: International Standards for the Treatment of Drug Use Disorders

Excerpted from International Standards for the Treatment of Drug Use Disorders[3]

Principle 1: Treatment should be available, accessible, attractive, and appropriate

Standards

1.1 Essential treatment services for drug use disorders should be available at different levels of health systems: from primary health care to tertiary health services, with specialized treatment programmes for substance use disorders.

1.2 Essential treatment services include: outreach services; screening and brief psychosocial interventions; diagnostic assessment; out-patient psychosocial and pharmacological treatment; the management of drug-induced acute clinical conditions (such as overdose, withdrawal syndrome); inpatient services for the management of severe withdrawal and drug-induced psychoses; long-term residential services; the treatment of comorbid substance use and psychiatric and physical disorders; and recovery management services delivered by trained clinicians.

1.3 Selected and properly trained peers can work in treatment services, providing specific interventions aimed at helping identify patients, engage them and keeping them in treatment.

1.4 Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.

1.5 It is necessary to extend low threshold and outreach services, as part of a continuum of care, to the 'hidden' populations most affected by drug use, but often unmotivated to receive treatment or that relapse after a treatment programme.

1.6 Within a continuum of care, people with drug use disorders should have access to treatment services through multiple entry points.

1.7 Essential treatment services for drug use and related disorders should be available during a sufficiently wide range of opening hours to ensure access for individuals with employment or family responsibilities.

1.8 Essential treatment services should be affordable to clients from different socio-economic groups and levels of income with minimized risk of financial hardship for those requiring the services.

1.9 If not otherwise accessible, affordable, or available, treatment services should also provide access to social support, general medical care and the management of comorbid substance use disorders, as well as psychiatric and physical health conditions.

1.10 There is a need to put information on the availability and accessibility of essential treatment services for drug use disorders within easy reach, using multiple sources including the Internet, printed materials, and open access services.

Principle 2: Ensuring ethical standards of care in treatment services

Standards

2.1 In all cases, treatment services for drug use disorders should respect the human rights and dignity of patients and never use humiliating or degrading interventions.

2.2 The patients should grant informed consent before treatment begins and have a guaranteed option to withdraw from treatment at any time.

2.3 Patient data should be strictly confidential. Circumventing the confidentiality of health records in order to register patients entering treatment should be prohibited. Legislative measures, supported by appropriate staff training and service rules and regulations, should ensure and protect the confidentiality of patient data.

2.4 Staff of treatment services should receive proper training in the delivery of treatment in full compliance with ethical standards and human rights principles, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.

2.5 Service procedures should require staff to adequately inform patients of treatment processes and procedures, including their right to withdraw from treatment at any time.

2.6 Any research conducted in treatment services involving patients should be subject to the review of human research ethical committees. Ethical committees are encouraged to consider the opinions of people who have experienced drug use and drug treatment and are recovering from drug use disorders. The participation of patients in the research should be strictly voluntary, with informed written consent obtained in all cases.

2.7 Ethical standards of care in treatment services should apply to all populations with special treatment and care needs, without discrimination.

Principle 3: Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services

Standards

3.1 Treatment for drug use disorders should be provided predominantly in health and social-care systems. Effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social care services for people in contact with the criminal justice system.

3.2 Effective treatment should be available to people who offend and have drug use disorders and, where appropriate, be a partial or complete alternative to conviction or punishment.

3.3 Appropriate legal frameworks should safeguard the treatment of drug use disorders when used as an alternative to incarceration or provided within criminal justice settings.

3.4 Criminal justice settings should provide opportunities for individuals with drug use disorders to receive parity of treatment, health, and social care that are available in the community.

3.5 Treatment interventions should not be imposed on individuals with substance use disorders in the criminal justice system against their will.

3.6 Individuals with drug use disorders in criminal justice settings should have access to essential prevention and treatment including: the mechanisms of early identification and referral to treatment; the prevention of the transmission of blood-borne infections; pharmacological and psychosocial treatment of drug use disorders and comorbid substance use disorders as well as psychiatric and physical health conditions; rehabilitation services and through-care links with community health; and social services in preparation for their release.

3.7 Training for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals, should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and to support treatment and rehabilitation efforts.

3.8 The treatment of drug use disorders in the criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.

3.9 Treatment for drug use disorders and comorbid conditions should be an essential part of the social reintegration of prisoners with drug use disorders. Additionally, there is a need to ensure the continuity of treatment for drug use disorders in all cases through the effective coordination of health and social care services in communities and criminal justice settings. This will reduce the risk of relapse, overdose, and reoffending.

3.10 All efforts should be made to reduce the burden of stigma and prevent discrimination directed at people with mental and substance use disorders who attend medical services while in contact with the criminal justice system.

Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders

Standards

4.1 Resource allocation for the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of treatment interventions.

4.2 A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social care systems, with the appropriate integration of pharmacological and psychosocial interventions within a continuum of care.

4.3 Treatment services should be gender-sensitive and oriented towards the needs of the populations they serve, with due respect for cultural norms and the involvement of patients in the service design, delivery, and evaluation.

4.4 Primary health care professionals should be trained in the identification of drug use, as well as the diagnosis and management of drug use disorders and related health conditions.

4.5 The treatment of drug use disorders in primary health care should be supported by specialized services with the required skills and competences, particularly for the treatment of severe cases and patients with comorbid psychiatric and physical health conditions.

4.6 Whenever possible, the organization of specialized treatment services for drug use disorders should feature multidisciplinary teams trained in the delivery of evidence-based interventions. The teams in addition need to have competencies in medicine, psychiatry,

clinical psychology, nursing, social work, and counselling. They should involve people with lived experience of drug use and drug treatment who are in recovery.

4.7 Individual needs should determine the duration of treatment, with no pre-set limits and the possibility of modification at any point, based on the patient's clinical needs.

4.8 The training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education including university curricula and programmes of continuing education.

4.9 There is need to update guidelines for the treatment of drug use disorders, procedures and norms regularly to keep up with new evidence of the effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research.

4.10 Treatment services should benchmark their performance against standards for comparable services.

4.11 The development of new treatment interventions should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.

Principle 5: Responding to the special treatment and care needs of population groups

Standards

5.1 Service provision for drug use disorders and service treatment protocols should reflect the needs of specific population groups.

5.2 Special treatment services should be in place for children and adolescents with drug use disorders to address the specific treatment needs associated with this age group. Differentiated treatment services for children and adolescents should be provided whenever possible to secure the best possible treatment outcomes.

5.3 Treatment services and interventions should be tailored to the needs of women and pregnant women. This is relevant for all aspects of their intervention's design and delivery, including location, staffing, programme development, child friendliness and content.

5.4 Treatment services should be tailored to the needs of people from minority groups with drug use disorders and provide them with cultural mediators and interpreters whenever necessary to minimize cultural and language barriers.

5.5 Social assistance and support packages should be integrated into the treatment services for people with drug use disorders, particularly those without social support, such as those who are homeless or unemployed.

5.6 Outreach services should be in place to establish contact with people with drug use disorders who may refrain from seeking treatment because of stigma and marginalization.

5.7 All efforts should be made to reduce the burden of stigma and discrimination faced by people with mental and substance use disorders, including through public awareness-raising and anti-stigma campaigns, dissemination of correct information about substance use disorders, reducing structural barriers to treatment and implementing measures to enhance the self-efficacy of people with drug use disorders.

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders

Standards

6.1 Treatment policies and plans for substance use disorders should be formulated by relevant governmental and other authorities, as appropriate, and should be based on the principles of universal health coverage, consistent with the best available evidence and developed with the active involvement of key stakeholders, including the target populations, patients, family and community members and NGOs.

6.2 Written service policy and treatment protocols should be available, known to all staff and guide the delivery of treatment services and interventions.

6.3 Staff working in specialized services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support, and clinical supervision. Clinical supervision, mentoring, safety protection measures and other forms of support are needed to prevent 'burnout' among staff members.

6.4 Policies and procedures for staff recruitment and performance monitoring should be clearly articulated and known to all.

6.5 A sustainable source of adequate funding should be secured, and proper financial management and accountability mechanisms put in place. Whenever possible, the relevant budget should include resources for on-going staff education, and the evaluation of service quality and performance.

6.6 Services for the treatment of drug use disorders should network and link with all levels of health care including primary and specialized health services, social services, and others as appropriate in order to provide comprehensive care to their patients.

6.7 Patient record and data collection systems in line with international indicators should be in place to ensure accountability and continuity of treatment and care, while respecting patient confidentiality.

6.8 It is essential to revise service programmes, rules, and procedures periodically, and develop mechanisms of continuous feedback, audit, monitoring and evaluation (including feedback from patients).

6.9 Patterns of drug use and related health and social consequences and substance use, psychiatric and physical health comorbidities should be regularly monitored, and results made available to help the planning and governance of treatment services.

Principle 7: Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation.

Standards

7.1 Policies and plans for the development of systems for the treatment of drug use disorders should support an individualized, holistic, and integrated treatment approach as well as linkages to complementary services within and outside the health sector.

7.2 Links between efforts to prevent drug use, treat drug use disorders and reduce health and social harms associated with drug use should be established and operational.

7.3 Links between communities (involving families, caregivers, mutual-support and self-help groups, relevant religious and community settings), social services (such as those delivered in educational, sport and recreational facilities), the criminal justice system and primary health care and specialized health services should be established and operational, with full respect for the confidentiality of patients' data.

7.4 Treatment system planning and development should be based on estimates and descriptions of the nature and extent of the drug problem and the characteristics of the population in need.

7.5 The roles of national, regional, and local agencies in the different sectors responsible for the delivery of treatment and rehabilitation of drug use disorders should be defined, with mechanisms established for effective coordination.

7.6 Quality standards for drug treatment services should be developed and established with appropriate mechanisms for ensuring compliance, quality assurance or accreditation.

7.7 Each service should have mechanisms of clinical governance, monitoring and evaluation in place, including clinical accountability, continuous monitoring of the patient's health and well-being, and intermittent external evaluation.

7.8 Information on the number, type, and distribution of services available and the utilisation of the treatment system should be monitored for planning and development purposes.z

APPENDIX B: Canada's Adherence to the International Standards for the Treatment of Drug Use Disorders — Overview

Table 1. Data for Figure 1, Review of Canada's DTC adherence to the international standards for the treatment of drug use disorders, based on the *International Standards for the Treatment of Drug Use Disorders*[3]

Principle Description	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11
P1: Treatment should be available, accessible, attractive, and appropriate	Y	P	P	P	N	N/A	U	Y	P	Y	—
P2: Ensuring ethical standards of care in treatment services	Y	N	N	N	N	Y	N	—	—	—	—
P3: Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services	N	Y	N	P	N	P	U	N	P	N	—
P4: Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders	N	N	P	Y	P	P	N	U	N	U	N
P5: Responding to the special treatment and care needs of population groups	N	N/A	N	N	P	N/A	N	—	—	—	—
P6: Ensuring good clinical governance of treatment services and programs for drug use disorders	N	U	U	N/A	P	P	N	N	U	—	—
P7: Treatment services, policies and procedures should support an integrated treatment approach and linkages to complementary services require constant monitoring and evaluation	N	N	N	Y	U	N	P	Y	—	—	—

Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications in DTCs. N/A = not applicable; — = no standard for the respective number; P = partial adherence; U = unknown; Y = adheres to; N = does not adhere to

APPENDIX C: Canada's Adherence to the International Standards for the Treatment of Drug Use Disorders — Principles 2, 3 and 4

Table 2. Data for Figure 2, Principle 2: Ensuring ethical standards of care in treatment services, based on the *International Standards for the Treatment of Drug Use Disorders*[3]

Standard	Standard Description	Adherence
2.2	The patients should grant informed consent before treatment begins and have a guaranteed option to withdraw from treatment at any time.	P
2.3	Patient data should be strictly confidential. Circumventing the confidentiality of health records in order to register patients entering treatment should be prohibited. Legislative measures, supported by appropriate staff training and service rules and regulations, should ensure and protect the confidentiality of patient data.	N
2.4	Staff of treatment services should receive proper training in the delivery of treatment in full compliance with ethical standards and human rights principles, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.	P
2.5	Service procedures should require staff to adequately inform patients of treatment processes and procedures, including their right to withdraw from treatment at any time.	N

Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications in DTCs.
P = partial adherence. U = unknown. Y = adheres to. N = does not adhere to
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Table 3. Data for Figure 2, Principle 3: Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services, based on the *International Standards for the Treatment of Drug Use Disorders*[8]

Standard	Standard Description	Adherence
3.1	Treatment for drug use disorders should be provided predominantly in health and social care systems. Effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social care services for people in contact with the criminal justice system.	N
3.2	Effective treatment should be available to people who offend and have drug use disorders and, where appropriate, be a partial or complete alternative to conviction or punishment.	Y
3.3	Appropriate legal frameworks should safeguard the treatment of drug use disorders when used as an alternative to incarceration or provided within criminal justice settings.	N
3.4	Criminal justice settings should provide opportunities for individuals with drug use disorders to receive parity of treatment, health and social care that are available in the community.	P
3.5	Treatment interventions should not be imposed on individuals with substance use disorders in the criminal justice system against their will.	N
3.7	Training for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals, should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and to support treatment and rehabilitation efforts.	U
3.8	The treatment of drug use disorders in the criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.	U
3.9	Treatment for drug use disorders and comorbid conditions should be an essential part of the social reintegration of prisoners with drug use disorders. Additionally, there is a need to ensure the continuity of treatment for drug use disorders in all cases through the effective coordination of health and social care services in communities and criminal justice settings. This will reduce the risk of relapse, overdose and reoffending.	P
3.10	All efforts should be made to reduce the burden of stigma and prevent discrimination directed at people with mental and substance use disorders who attend medical services while in contact with the criminal justice system.	N

Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications in DTCs. P = partial adherence. U = unknown. Y = adheres to. N = does not adhere to

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Table 4: Data for Figure 2, Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders, based on the *International Standards for the Treatment of Drug Use Disorders*[3]

Standard	Standard Description	Adherence
4.1	Resource allocation for the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of treatment interventions.	P
4.2	A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social care systems, with the appropriate integration of pharmacological and psychosocial interventions within a continuum of care.	P
4.3	Treatment services should be gender-sensitive and oriented towards the needs of the populations they serve, with due respect for cultural norms and the involvement of patients in the service design, delivery and evaluation.	P
4.5	The treatment of drug use disorders in primary health care should be supported by specialized services with the required skills and competences, particularly for the treatment of severe cases and patients with comorbid psychiatric and physical health conditions.	P
4.6	Whenever possible, the organization of specialized treatment services for drug use disorders should feature multidisciplinary teams trained in the delivery of evidence-based interventions. The teams in addition need to have competencies in medicine, psychiatry, clinical psychology, nursing, social work and counselling. They should involve people with lived experience of drug use and drug treatment who are in recovery.	P
4.7	Individual needs should determine the duration of treatment, with no pre-set limits and the possibility of modification at any point, based on the patient's clinical needs.	P
4.9	There is need to update guidelines for the treatment of drug use disorders, procedures and norms regularly to keep up with new evidence of the effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research	U
4.10	Treatment services should benchmark their performance against standards for comparable services.	U
4.11	The development of new treatment interventions should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.	N

Note: Each comparison reflects publicly available information; however, there may be discrepancies with the actual applications in DTCs.
P = partial adherence. U = unknown. Y = adheres to. N = does not adhere to
Return to Figure 2

Suggested citation: Berg, D. & Burke, H. (2023). *Comparing drug treatment court principles to evidence-based practice.* [Policy brief]. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

ISBN 978-1-77871-112-1

Canadian Centre on Substance Use and Addiction

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CCSA activities and products are made possible through a financial contribution from Health Canada. The views of CCSA do not necessarily represent the views of the Government of Canada.